PATIENT INFORMATION

Legal Name: Last _____First _____ Middle_____

Social Security #_____Date of Birth _____ Gender_____

Address _____City_____State_____

Zip Code _____ Employer _____ Occupation _____

Home Phone _____Cell Phone _____Work Phone _____

Emergency Contact_____

INSURANCE INFORMATION

Subscriber Name _____ Relationship to Patient _____

Subscriber Social Security #_____ Subscriber Date of Birth _____

Primary Health Insurance Company _____

Secondary Health Insurance Company_____

Tertiary Health Insurance Company _____

RESPONSIBLE PARTY/LEGAL GUARDIAN INFORMATION

Please complete only if patient is a minor.

Legal Name: Last _____First _____ Middle_____

Social Security #_____Date of Birth _____Gender_____

Address _____City_____ State_____

Zip Code _____ Employer _____ Occupation _____

Home Phone _____Cell Phone _____Work Phone _____

It is the policy of this office that the adult presenting the child for treatment is responsible for the payment of the patient at the time of service.

I authorize the release of medical information to my primary care or referring physician for consultations and as necessary to process insurance claims. I also authorize payment of medical benefits to the physician.

In order to establish optimal relations with our patients and to avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform patients of the financial payment policies of this office. Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service, and all non-covered or cosmetic procedures are payable in full at time of service. We accept payment in the form of cash, check or credit card. Your signature below signifies your understanding and willingness to comply with this policy.

Patient, Responsible Party, or Legal Guardian Signature:_____Date:_____